THE SENIOR CENTER AT CASCADES

MEMBERSHIP FORM

JULY 1 2013 – JUNE 30, 2014

Department of Parks, Recreation and Community Services/Area Agency on Aging 21060 Whitfield Place, Sterling, VA 20165 571-258-3280

_	ROVIDE YOUR EMA SLETTER, GENERA	L INFORMA <u>TIO</u> N	, AND/OR TF	RIPS UPDATE	· -
by the Area Agency on a not shared with any oth	irement for Senior Programs is Aging (AAA) and the Virginia L er organization or individual w PLEASE PRINT AND C	Department for the Aging. It is thout your consent and ser	Membership forms a ve as a health form j	re kept in a secure env for senior day trips.	
Last Name		First Name		M.I	
	// 19 h Day Year	Preferred First N	ame		_
Mailing Address: _			Apt	#:	
City:	Cour	nty:	State:	Zip:	
Telephone: (home)	()_	(work) (_)		
(cell) ())	other:			
(Membership fee is Emergency Contact	County resident?	for non-residents, chec			
1st Contact Phone: (hor	me)	_ (work)	(cell)		_
2nd Contact Name:		R	elationship:		
2nd Contact Phone: (ho	me)	(work)	(cell)		
PLEASE CIRCLE AF	PROPRIATE RESPONSE:				
Annual household i	ncome: For family of or For family of tw		w or \$11,491 o w or \$15,511 o		
Family in Home:	Yourself Spouse	Dependent other	ers		
Gender:	Male or Female				
Martial Status:	Married Widowed	Separated Div	orced Single	,	
Race:	African American W American Indian/Alask Other	an Native Two or m	ative Hawaiian o ore races combin	r Pacific Islander ed	Asian
Ethnicity:	Hispanic or Latino Orig	in <u>or</u> Not Hispani	c or Latino Origi	n	

- please complete medical information on back side and sign

Medical information is requested for your protection when participating in Loudoun County Senior Programs (including meal program). As with all information, we maintain strict rules of confidentiality designed to protect your privacy. This form also serves as your health form for senior day trips.

Last Name Preferred First Name Physician's Name: City: Physician's Phone: () Overall Health: Excellent Good Fair All Allergies:	State: Poor
Physician's Phone: ()	Poor
Overall Health: Excellent Good Fair All Allergies:	
All Allergies:	
All Medical Conditions or Diagnoses:	
All Current Medications (include over the counter) Dose and Frequency (mg./x per day)	Reason Prescribed
(=====================================	
Communication: English other (specify)	
cannot communicate hearing impaired	
Member Agreement:	sign/gestures
I recognize that all activities, classes, trips and transportation provided by the Dep Community Services (PRCS) involve some risk and, by registering for a specific	
understand possible risks involved with this type of activity. Furthermore, I understa	nd that Loudoun Count
not be responsible for me when I am traveling to and from an activity via transporta Loudoun. Also, by signing below, I give permission for Loudoun County PRCS to us	e photographs and vide
publicity in order to increase community awareness of PRCS programs and in publimitation.	blications and other me
Signature: D	
You have my permission to allow qualified volunteers, who have agreed to and signed a Loudoun handle this document under the direction and/or supervision of Area Agency on Aging Staff. Yes No	County Confidentiality Ag
ADA – Loudoun County Department of Parks, Recreation and Community Services is comm Americans with Disabilities Act (ADA). If you need reasonable accommodations in order to par Community Center/Program Area at least one week prior to the start of the activity.	